Supreme Court, U.S.
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No._____

IN THE
SUPREME COURT OF THE UNITED STATES

William W. Ware,

Petitioner

V.

The Oregon Department of Human Services,

Respondent

From appeal of a judgment of the
Oregon Court of Appeals and denial of
Certiorari to the Oregon Supreme Court
Per final order of January 23, 2008 in
Oregon CA No. A 128709

PETITION FOR A WRIT OF CERTIORARI

William W. Ware
731 SW Salmon St.
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Pro se Petitioner

April 10, 2008

QUESTIONS PRESENTED FOR REVIEW

1. Did Respondents violate the Medicaid Act by terminating Petitioner's coverage while he was undertaking treatment for tuberculosis?

2. Did the actions of the Hearing Officer in terminating Petitioner's Medicaid coverage in the form of his Oregon Health Plan, ORS 414.018 et seq. (OHP hereafter) for an impoverished, disabled person *en extremis* or in the throes of health care crisis violate the letter and spirit of the Medicaid Act of 1965 and Medicare Acts.

3. Was denying Petitioner essential medical coverage violating his equal access to Medicaidmedical assistance programs and contrary to the Americans with Disabilities Act of 199?.

4. Did Respondent deny Plaintiff substantive and procedural due process rights in contravention of his 1st, 5th and 14th Amendments to the U. S. Constitution by terminating on-going treatments and courses of medications initiated while he lawfully received Medicaid and pending the initiation of his previously awarded Medicare program?

5. Do disabled persons dependent on continuous state medical care assistance have a right to be free from harmful or fatal acts, neglect and omission by the government under the United States Constitution?

6. Can a pro se petitioner, a licensed attorney, request and receive, in the event of successful appeal, attorneys fees for the first time in the case on appeal to the United State Supreme Court?

LIST OF PARTIES IN COURT BELOW AND CORPORATE DISCLOSURE STATEMENT

Petitioner William W. Ware is a private citizen of the State of Oregon. Respondent Department of Human Services is a branch of the state government of Oregon.

Neither party is or represents a corporation.

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CITATIONS OF OPINIONS AND ORDERS IN CASE

There are no reported cases appertaining to this cause. Copies of all relevant, unpublished orders are contained in the Appendices.

JURISDICTIONAL STATEMENT

The final judgment of the Oregon Supreme Court in a matter raising substantial Federal questions gives rise to jurisdiction per 28 U.S.C. 1357 (a).

CONSTITUTIONAL PROVISIONS AND STATUTES INVOKED

The United States Constitution and rights appertaining is evoked in reference to the 1st, 5th, 9th, 10th and 14th Amendments.

United States Statutes principally referenced are the Medicaid Act, 42 U.S.C. 1396a et seq., The American with Disabilities Act, (ADA) of 1990 Sec. 502, 42 U.S.C. Sec. 12132; the Rehabilitation Act of 1973, Sec 504.. The Oregon Health Plan. ORS 414.025 et seq. is also subject to inquiry. Argument by analogy is made referring to (EMTALA) 42 U.S.C.203 et seq.

STATEMENT OF THE CASE

Background

In February of 2003 Petitioner suffered from a variety of infirmities, some life threatening. He was duly enrolled in Medicaid/Oregon Health Plan and receiving care for these chronic conditions and illnesses. On February 1, 2004 the Social Security Administration awarded Petitioner full disability status. (SSD) Petitioner's medications and medical treatments continued until October 16, 2004 when Respondent terminated payments to his medical providers, stating that his SSD payment made him ineligible for Medicaid/OHP and that his Medicare coverage would not vest until February 1, 2006.

On or about November 13, 2004 Petitioner obtained, pro se, a temporary restraining order and subsequent to that a temporary injunction prohibiting Respondent from terminating his critical and necessary medical care via failure to pay his providers. On or about the 28th of December 2004 Petitioner initiated Respondents Medicaid/OHP Administrative Hearing process.

The Oregon Administrative Hearings Decisions

Following an February 15, 2005 administrative hearing, the Administrative Law Judge issued on March 25, 2005 a final order closing Petitioner's Medicaid/OHP benefits and from which timely appeal was perfected to the Oregon Court of Appeals. On July 28, 2005 Respondents per their affiliated agency, the Oregon Administrative Hearing office

(OAH) held another hearing regarding alleged overpayment of medical benefits. At both of theses hearings the Administrative Law Judges announced on the record there would be no consideration of Petitioner's duly documented challenges to the agency's statutory interpretations and the constitutional legalities of O.A.R. 461-195-0541 (1) and (2)(a) and (c) and 7 C.F.R. Sec. 273.18(1)(i). On September16, 2005 the OAH found that these regulations required the repayment of $2,728.98 from which timely appeal was perfected to the Oregon Court of Appeals and, on motion, the two causes were consolidated.

Following notice of termination and prior to exhaustion of administrative appeals regarding his medical coverage, Petitioner was unable to afford his daily medications, including his crucial diabetes and hypertension medicines. The immediate impact on his immunity system that brought opportunistic infections sending Petitioner to the Portland Providence Hospital Emergency Room approximately 7 times charitably and 7 times "billed," albeit reduced medical bills in excess of $2,962.40; far exceeding his monthly SSD income during that time, then Petitioner's sole source of income. Presentation of the Providence bills was made to the OAH Hearing Officer at the July 26 event without objection and duly noted for the record.

Petitioners Medicare benefits vested on February 1, 2006, but Respondents life threatening practices that discriminate against and injure the disabled during the two year gap between the

vesting of Medicare benefits and the cancellation of Medicaid continue to this day..

The Oregon Court of Appeals Decisions

On June 13, 2007 The Oregon Court of Appeals affirmed without opinion the orders of the hearing officers from which Petitioner made timely application for writ of certiorari to the Oregon Supreme Court.

The Oregon Supreme Court Decisions

On October 4, 2007 the Oregon Supreme Court denied Petitioner's petition for writ of certiorari and on January 23, 2008, they denied Petitioner's motion for reconsideration of their October 4, 2007 order without opinion on the issues set out and properly raised in at all stages and forums in this cause and properly here before this Court.

On February 14, 2008, on remand to the Oregon Court of Appeals the final judgment in this cause.

EXISTENCE OF JURISDICTION IN THE COURTS BELOW

The basis for appellate jurisdiction in the courts below was pursuant to Oregon Revised Statutes 183.480 et seq.

ARGUMENT FOR ALLOWANCE OF WRIT

General Considerations Petitioner is an aggrieved party adversely effected by Respondent Oregon Department of Human Services (DHS) and their interpretations of the statutes, rules and policies in issue. Petitioner is also disabled as defined by the Social Security Act and a member of the discrete class of individuals adversely affected by the acts, omissions, negligence and policies in question. Petitioner seeks statutory, constitutional and equitable relief. At all relevant times Petitioner remained in need of critical medical treatment for a variety of ailments, some life threatening. During this time Oregonians died or were seriously injured due to the Federal and State policies and practices brought into question.

The First Amendment to the United States Constitution guarantees the right to petition for redress of grievance. Crucial and substantial Federal questions raised herein have not been judicially reported to date.

And though your Petitioner may be the child of a lesser God, he not the child of a lesser law.

The issues raised pertain to life and death. Petitioner contends the statutes fully support his claim for continuation of Medicaid coverage between award of Social Security Disability and vesting of his Medicare coverage for continuation and/or completion of treatment and courses of medication initiated before the two year gap presumed by

Respondents to exist between Medicaid and Medicare coverage. If this view of the statutes does not prevail, then it boils down to whether there exists for disabled people already dependent on federally funded medical assistance a constitutional right to live by providence of necessary and/or critical health care.

In the broader context of health care policy and proper venues for such a discussion would be the Oregon Legislature, or the United States Congress. However, in the far narrower context of the facts of this case and regarding chronically ill and/or disabled persons dependent on Medicaid/OHP medical assistance, the Courts have a role in interpreting laws consistent with the principles of our Founders and the conscience of a civilized people. Sadly, it falls on this Court by default of the more or less constitutionally deaf "hearing process" and lower courts to consider these matters regarding basic human decency.

Initially the hearing officers refused to entertain arguments or evidence for the purpose of calling into question the statutory interpretations and constitutional issues raised in this appeal. The appellate process is the only avenue for redress of these grievances.

Quoting from the findings of fact in the Final Order of the Administrative Hearings for The Department of Human Services: "Claimant has numerous, serious medical problems, for which he recently started receiving treatment. Claimant strenuously objects to the termination of his medical

benefits when he just started treatment and is still very ill." See Appendix E.

Petitioner's Medicaid/OHP was terminated while undergoing said treatments. His diseases did not take a time out waiting for his Medicare to vest.

Respondent seeks payment of $2,728.98, the amount allegedly expended for crucial and Necessary medical by Medicaid via the OHP Petitioner received during the Oregon Administrative Hearing appellate process. Petitioner contends these were treatments and medications initiated while his Medicaid/OHP was not in dispute and necessary in terms of their amount, scope, duration to fulfill the federal legislative mandate Overruling the orders of the hearing officers are supported by the following:

1. Respondents violated the Medicaid Act by terminating Petitioner's coverage while he was undertaking treatment for tuberculosis

The hearing record indicates that at the time of termination Petitioner was undergoing treatment for tuberculosis. Respondent illegally terminated coverage prior to this appeal in blatant violation of 42 U.S.C. 1396a-(z) (2) (B). (C). (D) (E) and especially "(F) Services...designed to encourage completion of regimens of prescribed drugs by out-patients, including services to observe directly the intake of prescribed drugs." (pp. 611-612) 42 U.S.C. 1396 (a) (10) (A) (ii) (XII) specifically excepts tuberculosis-infected individuals from automatic Medicaid disability income eligibility exclusion, (ibid. pp. 565-567). It also happens that monitoring of and

sustaining of treatment for Petitioners diabetes, high blood pressure and emotional issues are necessary for a good outcome of the tuberculosis treatment and the above-denominated statutes contemplate such ancillary treatments.

Hence Respondents original notice of termination, termination, notice of repayment and subsequent hearings should be held null and invalid and the alleged $2,728.98 overpayment declared a nullity and recompense should be disallowed as a matter of law. Further, the $2,962.40 owed to Providence Hospital on Petitioners account for medical services rendered, billed and unpaid while his Medicaid/OHP was lawfully in force should be paid in full by the Respondents.

2. The Hearing Officer in termination of Petitioner's Medicaid, interrupting on-going crucial medical care violated the letter and spirit of the Medicaid and Medicare Acts.

Upon receipt of Social Security Disability (AKA SS, part B) status and payments, Petitioner was duly enrolled in the OPH and otherwise certified "disabled," "categorically needy" and "medically needy." At the time of termination Petitioner's medical costs for medication and treatment of life threatening conditions on the open market equaled or exceeded his gross income. Petitioner's Portland Providence bills for treatment of chronic illness in the amount of $2,962.40 demonstrate catastrophic outcomes from elimination of coverage for a categorically needy Medicaid recipient and an actionable harm. "Once a state chooses to offer such

optional services it is bound to act in compliance with the Act and the applicable regulations in the implementation of those services, including the requirement that such services be sufficient in amount, duration and scope." Weaver v. Reagan, 866 F. 2d 194, 197 (8th Cir. 1989).

The law is codified in 42 U.S.C 1396a (b)(3) and under C.FR Secs, 440.210 & 440.220. They command that Medicaid agencies may not arbitrarily deny or reduce "the ***amount, duration or scope of a required service*** (emphasis supplied), to an otherwise eligible recipient solely because of the diagnosis, type of illness or condition." It does not authorize second-guessing medical necessity and prohibits canceling treatments in progress. "The Medicaid statute imposes a duty on the state to provide safeguards necessary to assure that eligibility for care and service under Medicaid will be determined in a manner consistent with the best interests of recipients." Arnold v Carney by Kimble, 779 F. Supp. 925, 936, (ND Tenn. 1990).

That some Medicaid recipients in the throes of medical crisis might become technically ineligible and require continued, on-going medical assistance is contemplated by 42 U.S.C. 1396a (b)(3) which provides "medical assistance on behalf of aged, blind or disabled individuals whose income and resources are insufficient to meet the costs of necessary medical services as well as to the medically needy which includes certain individuals whose income is insufficient to meet the costs of medical treatment," Sobky v Smoley, 855 F. Supp. 1123, 1127, see n. 4 (ED Cal. 1994).

A recent decision further elucidates this principle: (State programs should promote) "Medicaid's aim of providing medical services to those who's income and resources are insufficient to meet the costs of necessary medical services even if the individual is not poor enough to qualify for Medicaid." Pharmaceutical Retail and Mfg. v Walsh, 538 U.S. 644, 659, 155 L. Ed 2d 889, 903, 123 S. Ct. 1855, 1870 (2003).

Hence income caps that declare that an award of Social Security Disability that exceeds by a small margin exceed the cap on technical Medicaid eligibility requiring the recipient of SSD to wait 2 years for his Medicare to vest before receiving continuation of medical assistance violates the letter and spirit of the Medicaid Act.

Perhaps the Social Security concept of "spend down rule" suggests a method of calculation whereby necessary medical bills can be deducted from the net amount in determination of eligibility. The rule is codified in 42 U.S.C 1396 (a) (14) (A) or (1-5) or (7) are conditioned by 42 U.S.C 1396a (b) (17) and clarified by CFR 436.3: "Medically needy means...disabled individuals... listed in Subpart D and who may be eligible for Medicaid under this part because their income and resources are within limits set by the state under it's Medicaid plan...including persons whose income and resources fall within these limits after their incurred expenses for medical ...can be deducted."

Interpreting this rule, Medicaid administrators were ordered to construe the Medicaid statute to require a spend down of recipients putative income when initiation of SSP payments placed a widow beyond the state Medicaid eligibility requirement, Darling v Sullivan, 914 F. 2d 132, 133, Footnote 3 (8th Cir. 1990). A spend down that includes only medical bills makes even more sense. Judge Friendly, interpreting the Medicaid Act, wrote "Congress therefore has seen fit to protect only a modest portion of a recipient's income against recapture and to allow the rest to be used to meet their medical needs." Freidman v Berger, 547 F.2d 724, 732 (2d Cir. 1976).

Friedman, like our case, turned on the question of discrimination or distinctions between Social Security based categorically needy and the medically needy and the compelling exigencies evoking the "spend down" provisions of the Medicaid Act..

In Thom v Aggrey, 455 F. Supp.1, 7 (ND Ohio 1977) the court held that individuals with medical expenses reducing their income below the state standard cannot be held ineligible for state assistance solely on the grounds their gross income exceeded an arbitrary ceiling.

The law is at the very least ambiguously stated by the Medicaid Act and C.F.R., "Ambiguity of a statute is no shield for states from substantial compliance with the goals of Medicaid." Albislun v Maine, 7 F. 3d 258, 266 (1st Cir. 1993).

Congressional intent in this regard is clear and convincing: "Medicaid determinations "take into account only such income and resources as...are actually available to the applicant or recipient... These provisions are designed so that the states will not assume the availability of income which may not in fact be available." Senate Report No. 404. 89th Cong. 1st Session, 78 (1965); HR Report No 213, 89th Cong., 1st Session 78 (1965)

Contrary to the Congressional intent behind the Medicaid statutes, Respondent's own recent studies show that even the slightest economic hurdles set up by Respondent, never mind Petitioner's virtually insurmountable financial barriers, result in loss of necessary health care and ghastly medical outcomes:

"Those who left...were far more likely than those who left for other reasons not to have received needed care in the previous six months...(and) more likely to have skipped buying prescriptions. There were also more likely to report using the E.R. as the usual source of care." From "The Impact of Increased Cost Sharing on Medicaid Enrollees-Changes Have Caused an Exodus. Amongst the Poorest" Bill Wright, et al.. Datawatch, p 1110 July-Aug. 2005.

Here is further evidence that Congress wished to avoid the dire impacts set out above with a medical spend down requirement in Medicaid:

"The state may require the use of all the excess income of the individual toward his medical expenses or some proportion of that amount. In no event,

however, with respect to 42 U.S.C 1396 (a) (14) (A) or (1-5) or (17) described below with reference to the use of deductibles for certain terms of medical services a state require the use of income or resources which would bring the individual's income below the amount established as the test of eligibility under the state plan. Such action would reduce the individual below the level as necessary for his maintenance." Senate Report No. 404, 89th Cong., 1st Session (1965).

"Congress, when it expends funds, and enacts legislation such as against discrimination and the Medicaid programs, has an obligation to see that funds are spent in accordance with the constitution and the moral sense of the nation." Remarks of Senator Humphrey, 110 Congressional Record 6544 (1964). (Senator Humphrey was the act's principal author.)

One closely analogous circumstance is the statutory imperative of hospitals to provide essential and critical medical care mandated by the Emergency Medical Treatment and Active Labor Act (EMTALA) 42 U.S.C. 13995dd (e) (3) (A) and our Oregon equivalent, ORS 441.094; Health care cannot be withheld because of inability to pay and requires that medical care be "provided immediately to sustain a person's life and to prevent serious permanent disfigurement." This is a clear indication of congressional public policy regarding whether or not the state can slam the door on necessary health care for infirm, vulnerable and seriously ill citizens. The more compelling and competing state interests favor sustaining essential health cares for our

chronically ill disabled that clearly lack the means to obtain it.

Petitioner submits that he and other disabled people should not be required to be rushed to the emergency room to receive continuation of medical care arbitrarily suspended by Respondents in the circumstances of our case.

3. Denying Petitioner essential medical coverage violated his right to equal access to Medicaid medical assistance programs contrary to the Americans with Disabilities Act.

Both literally and in every legal sense of the term, disability is the *sine qua non* of Petitioner's arbitrary elimination from the roles of Medicaid/OHP and such discrimination is actionable under the Americans with Disabilities Act of 1990 Sec. 504 et seq.; as visited via 42 U.S.C. Sec. 12132, Sec 504. State policies involving discrete, insular minorities such as the disabled in a manner contrary to the immediate medical needs of disabled Medicaid recipients are invalid when chronic illness is central to the disability.

Disparities in health care access between different categories of eligibility such as medically needy and categorically needy may, in some Circumstances, violate the ADA and other non-discrimination statutes, Linton by Arnold v Carney by Kimble, 779 F. Supp. 925, 936 (ND Tenn. 1990).

Oregon's own studies considered the illogical plight of disabled, dis-insured persons: "The

chronically ill without insurance also have greater access problems than the acutely ill without insurance, ' p 193, "Medicaid Program Changes and the Chronically Ill: Early Results from a Prospective Cohort Study of the OHP" Jennifer DeVoe, et al., Chronic Illness, Vol. 1, P. 191 2005.

It is blatantly discriminatory that sicker, disabled people have less access to health care than others of the categorically needy. "The ADA applies benefit of services by reason of such disabilities even if there are other contributory causes for the exclusion or denial." Henrietta D. v Bloomberg, 331 F3rd 261, 276 (2nd Cir.. 2003).

Analogizing to public building access cases, "the ADA does not mandate full accessibility to existing facilities, it does require that subsequent changes be done in a non-discriminatory manner," Kinney v Yerusalim, 9 F.3d 1067, 1075 (3rd Cir. 1993). Did Oregon's 2003 redesign contemplate the impact on the dis-enrolled disabled?

> Attempts to redesign Medicaid systems must take into account the likely effects of redesign on individuals and systems. For many individuals enrolled in Oregon's Medicaid program, the 2003 policy changes resulted in lost coverage, going without needed health care, and the accumulation of medical debt. But individual effect cascade into larger systems. As a state, Oregon quickly found itself facing a population of newly uninsured

> poor people with reduced access to primary care, higher rates of E.R. use, declining health and greater levels of medical debt." From p.16, "Impact of Changes to Premiums, Cost Sharing and Benefits on Adult Medicaid Beneficiaries; Results From an Ongoing Study of the Oregon Health Plan," Bill J. Wright, et al. Commonwealth Fund Pub. No. 848, July 2005.

Subsequent interpretations to the OHP fall short of the Yerusalim ADA requirement and earnest consideration per the ADA prohibition of disparate impact to the disabled; no such study, examination or discussion was ever reported and apparently never held when OHP roles were scaled down by Respondents.

"Where clearly identified disability related challenges that make access more difficult for plaintiffs (we) found accommodating scheme broken... we therefore hold that the plaintiff's disabilities were a substantial cause of their inability to obtain services or that the inability was not so remotely or insignificantly related to their disabilities" Henrietta, 331 F.3d 261 at 279.

Disabled persons by definition have a diminished capacity to respond to changes, earn more income and avoid disparate impacts of terminated Medicaid benefits. The facts herein are the very essence of an ADA violation.

4. Respondents denied Petitioner substantive and procedural due process rights in contravention of his 1st, 5th and 14th Amendments to the U. S. Constitution by terminating on-going treatments

Allowing a gaping hole in the Medicaid safety net for indigent, SSD qualified people defies rational contemplation and requires remediation by this Court to comport agency actions with substantive due process rights under the 5th and 14th Amendments to the United States Constitution. It is axiomatic of administrative law that an agency's explanation of the basis for a decision must have "a rational connection between the facts found and the choices made." Motor Vehicle Mfg. Association v State Farm Mutual Ins., 463 U.S. 29, 43, 77 L. Ed 2d 443, 458, 103 S. Ct. 2896 (1983), "Agencies must rely on facts in the record and its decision must rationally relate to those facts." Bowen v American Hospital Association, 476 U.S. 610, 626, 90 L. Ed 2d 584 597, 106 S. Ct. 2101 (1986).

"Survival and health of the Medicaid recipient are the paramount values of the Medicaid Act superseding state interests." Planned Parenthood v Casey, 505 U.S.D 833, 879, 120 L. Ed 889, 903, 123 S. Ct.1855 (2003). As Justice Thomas recently wrote, "Unexplained inconsistency is, at most, a reason for holding an interpretation to be an arbitrary and capricious change under the Administrative Procedure Act," National Cable & Telecommunications Assn. v. Brand X Internet Services, 545 U.S. 975, 981 162 L. Ed 2d 820,834 *** S. Ct.*** (2007). Similarly, "the (agency) has failed to set forth the required explanation because it's

proffered rationale remains unsupported by any record evidence and contradicted by the evidence submitted by the networks." Fox Television Stations v. FCC, 489 F.3d 444, 460, n.10 (2nd Cir. 2007).

The Fox due process case analysis is even more compelling here in that the agency has never anywhere on record given a rational justification for the two year gap between Medicaid and Medicare coverage. The presumed two year gap for medically needy persons declared to be eligible for SSD, in the face of Medicaid's mandates to care for the chronically ill and disabled is at best an urban legend of the law.

Petitioner submits Respondent and other agencies continue dumping disabled, seriously ill people from Medicaid coverage solely because no one has yet challenged this barbaric practice.

"State plan for determining eligibility must be reasonably consistent with the objectives of the Medicaid act." Beal v Doe, 432 U.S. 438, 445 n.9, 53 L.Ed2d 464, 492, S. Ct. 2366, 2371 (1977). Federal supremacy doctrine clearly mandates that OHP follow Federal Medicaid rules:

"Many courts have exercised equitable powers to force a state to make or continue making public relief payments until the state's administration of its public aid program comports with federal statutory or constitutional standards." King v Smith, 392 U.S. 309, 334, 20 L. Ed 2d 1118, 1135, 88 S. Ct. 2128, 2134 (1968). Interpreting state statutes, courts may lend: "considerable deference to the evaluation

made by the institution itself absent proof that it's standards and its application of them serve no purpose..." (in this case by discrimination against handicapped people), Doe v New York University, 666 F. 2d 761, 776 (2d Cir. 1981).

Respondent again ignores it's own data and studies known to their experts while setting arbitrary eligibility standards. Even the slightest economic hurdles for indigents result in loss of necessary health care and catastrophic medical outcomes. Respondent's study of a 2003 wholesale reduction of the Medicaid/OHP eligibility roles showed those dumped experienced:

> "...high out of pocket costs and worse health" and "Reduced access to ...health care can have long term financial and health consequences for Medicaid beneficiaries, and will potentially drive up health care costs for all of U. S. as more uninsured individuals are treated in emergency rooms rather than from primary care providers." Impact of Changes to Premiums, Cost-Sharing & Benefits on Adult Medicaid Beneficiaries: Results from Ongoing Study of The Oregon Health Plan," Bill J Wright, The Commonwealth Fund, July 2005.

Sadly, Respondent possesses data detailing potential harsh impacts regarding potential harsh medical outcomes per Respondent's own in-house experts and consultants for The Office for Oregon

Health Policy Research. Their recent study spills these facts:

> "Those who lost coverage were significantly more likely to report unmet needs for medical care, urgent care, mental health care and prescription medications than those who were continuously enrolled. Persons with chronic illness who lost coverage were more likely to report unmet health care needs. 64% of those with chronic illness who lost coverage were more likely to report unmet health care needs. 69% reported they could not afford their medications. Nearly (72%) of those with unmet health care needs indicated that cost was the main barrier. "The Impact of Program Changes On Enrollment, Access and Utilization in Oregon Health Plan Standard Population," Matthew Carlson, et al., Providence Center for Outcomes Research, Mar. 2005.

"Medical necessity is a paramount value of Medicaid that may in many instances override state legislation contravening same." Jaffe v Sharp, 463 F. Supp. 222, 231 (D Mass 1978). In the face of Medicaid and constitutional challenges of this order, even regarding prisoners "lack of funds, staff or facilities cannot justify the State's failure to provide appellants with the treatment necessary..." Ohlinger v Watson, 652 F.2d 775, 779 (9th Cir. 1981).

Declaring a limitation of 3 doctor visits for Medicaid recipients suspect without proper assurance of further, emergency care, the court wrote "State welfare regulations must have a rational basis for the distinctions." Curtis v Taylor, 625 F.2d 645, 650 (5th Cir. 1980). See footnote 7

> Florida argues that their goal of "saving money" is sufficient to uphold the regulations. It is not obvious without some analysis, that the plan will actually reduce state expenditures. Florida decisions not to fund all medically necessary physicians visits may have the undesired effect of preventing adequate treatment of illnesses until they create an emergency situation. Treatment may then be engthier and costlier than it would have it had been provided earlier" Taylor at 650 See Note 7.

In 2003 the Oregon Legislature made wholesale cuts in OHP without facing facts readily available to them from the state's own experts. They made no explicit decisions regarding the 24-month Medicaid/Medicare gap dilemma and defaulted the matter to this Court to clarify; especially when such deficiencies result in verifiable catastrophic health care outcomes.

In light of the goals and intent of the Medicaid Act, the only fair reading of the Oregon OHP 414.025 et seq. statute is that it confers eligibility on a categorically needy person pending their Medicare

vesting. One might argue Respondents interpretation of ORS 414.025 creates an ambiguous eligibility shell game that puts categorically needy persons in limbo in the Medicaid to SSD to Medicare dilemma. However, he goals of the statutes and constitutional implications require interpretation in favor of eligibility. Ambiguity is, again, no comfort here for Respondents, Albislun, 7 F. 3d at 266.

Bad outcomes lead to increased liability concerns for health care providers and further strains on economic interests; a central concern of the legislative goals of OHP. Emergency Room costs are staggeringly in excess of the costs of maintenance of basic care according to Respondents own studies:

"OHSU reported a 17% increase in E.R. utilization amongst the uninsured in the three months following the OHP changes," Lowe, R. McDonald J, "Changes in Access to Primary Care in the Oregon Health Plan, Office for Oregon Health Policy and Research, January 2004.

Another recent study of the impact of elimination of OHP for chronically ill patients confirms the Florida court's observations in Taylor on this false econ[illegible]ny:

"Concurrent with poorer reported health status and higher out-of-pocket spending, uninsured chronically ill people are less likely than the insured to see a physician regularly and are more likely to forgo care when it is needed. This lack of access to regular sources of care leads to higher rates of preventable hospitalization for ambulatory care,

sensitive conditions, and a decreased likelihood of receiving necessary follow-up with a primary care physicians after an emergency department visit for a chronic illness that did not result in hospitalization." p. 193 "Medicaid Program Changes and the Chronically Ill: Early Results from a Prospective Cohort Study of the OHP" Jennifer De Voe, et al. Chronic Illness, Vol. 1, P. 191, 2005.

Hence, Respondent's pence wise/pound foolish cost cutting policies do not achieve any rational relationship to the goals of economizing OHP, Medicaid and/or Medicare and lead to a great many irrational and tragic medical outcomes. Respondent's unreasoned and unreasonable policies in administering Medicaid/OHP led to Petitioner's catastrophic outcome of a life threatening infection that sent him to the emergency room a great number of times for lack of proper, much less expensive medical care previously available through Medicaid/OHP.

Petitioner's incontrovertible catastrophic outcomes resulting from Respondents arbitrary, policies raise this and similar cases to a constitutional law dimension. "State action of negligence that brought about death is "violative of substantial due process rights," Becerra v Unified Government of Wyanotte County Kansas City, 272 F. Supp. 2d 1223, 1225 (D. Kan 2003).

Respondent's unconscionable elimination of Petitioner from Medicaid/OHP during the presumed Medicaid/Medicare gap might easily have killed him.

In the case of Doug Schmidt, Respondent's similar neglect did kill him. See Appendix f..

5. Disabled persons dependent on continuous state medical care assistance have a right to be free from harmful or fatal acts, neglect and omission by the government under the United States Constitution

The absence of health care for disabled, chronically ill persons negligently leads to medical emergencies and calls into question substantive due process and other fundamental constitutional rights. "Substantive due process protects bodily integrity." Planned Parenthood of Southeast Pennsylvania v Casey, 505 U.S. 833, 847-849, 120 L. Ed 2d 674, 716 112 S Ct 2791 (1992).

Bodily integrity of the disabled and chronically ill demonstrably threatened by Respondents arbitrary policies. "One principle announced in Roe which has remained constant before and after Casey... Any abortion regulation must contain adequate provision for a woman to terminate the pregnancy if it poses a threat to her life or health. An adequate health exception.... is a *per se* constitutional requirement." Planned Parenthood of Idaho v Wasden, 376 F.2d 908. 922 (9th Cir. 2004) cert. den. 544 U.S. 948, 161 LEd2d 524, 1258 S. Ct. 941 (2005).

A human life possesses fundamental rights protected by the due process and, depending on who is presiding, other constitutional clauses. The standard for scrutinizing state action that might threaten ones very life is a right of such ultimate

magnitude requires the state demonstrate a compelling interest and may dictate less drastic means of achieving state interests. It has already been demonstrated that cuts in health care benefits for chronically ill recipients do not even achieve the vulgar result of budget savings.

Courts consistently hold that there is a "presumption in favor of life. This presumption arises from the explicit guarantees of a right to life in the U. S. Constitution, Amendments V & XIV ." Matter of Baby K, 832 F. Supp. 1022, 1030 (ED Va. 1993) (affirmed on other grounds, 16 F. 3d 590 (4th Cir. 1994).

At a guess, Petitioner and others similarly stationed would qualify as viable fetuses, commanding the same constitutional protections for "life and liberty" afforded the unborn under the U. S. Constitutional Amendments 5 and 14. Outside of the criminal context there is absolutely no authority supporting the proposition that either state or federal action can blatantly hazard the very life of a law- abiding citizen.

State actions that are invasive of patient/client relationships and otherwise contrary to medical prerogatives were decisive constitutional considerations in the opinion of Justice Blackmun and the plurality in Roe v Wade, 146 U.S. 113, 135, 146,149, 163, 166, 153, L. Ed. 147, 173. 177, 175, 183, 184, 93 S. Ct. 705 (1973). This line of reasoning applies to the case at bar where bureaucrats supplant the expertise of physicians

with potentially dire consequences for Petitioner and the categorically and medically needy.

By way of further analogy, state actions resulting in forced medical procedures such as a stomach pump violate of substantive due process rights, Rochin v California, 342 U.S.165, 177, 96 L Ed 2d 183, 192, 72 S. Ct. 2505 (1952). The elimination of life sustaining medical care and medications that sent infectious microbes coursing through Petitioner's organism were far more invasive and life threatening than Rochin's stomach pump hose and call into question constitutional rights no less compelling. State actions or omissions connected to medical issues that threaten life or bodily injury are shocking and unconscionable per the Rocha rule.

United States Constitutional Amendment 9, reads "The Enumeration in the Constitution of certain Rights shall not be construed to deny or disparage others retained by the People;" and Amendment 10 states :"Powers not delegated to the United States nor prohibited are reserved to the States or to the people." These amendments are properly interpreted as contingency rules to deal with unforeseen circumstances and to guide the reading of statutes in a manner most favorable to the lives and welfare of the citizenry.

No less an authority on public health policies than former Oregon Governor Kitzhaber, also a former Emergency Room M.D., Professor and medical researcher recently wrote of one unlucky victim of Respondent's policies., In the year 2004

Douglas Schmidt paid the ultimate, incalculable price for our collective cupidity. The state of Oregon suspended his payments for daily anti-seizure medication . He had a grand mall seizure. Six months and a million dollars of medical care later he died. (Appendix F. p 22).

Having undertaken to assist Petitioner and those similarly situated in providing potentially life preserving treatment for a disabled citizen, the state cannot then withdraw that support against his will, medical necessity and in hazard of his health and very life. To do so is abhorrent to any standards of human decency.

Petitioner humbly submits that we who might be dependent on medical assistance possess a constitutional right not to be killed by our government as a result of state agency acts, omissions or neglect. Hence, the constitution recognizes a "right to life" for those universally regarded as living in this case of first impression.

6. A pro se attorney may request attorneys fees for petitioner Supreme Court for a writ of certiorari.

Petitioner has within the last 6 months reactivated his law license, including licenses to practice in a Federal District and Circuit Courts of Appeals. He believes continuation of this appeal is of vital interest to the citizens of his state and nation. Under 42 U.S.C. 1988 and the plenary powers of this Court, Petitioner requests an award of his reasonable attorneys fees for filing and prosecuting this petition for writ of certiorari.

CONCLUSION

For the reasons set forth above, it is respectfully requested this petition for writ of certiorari be granted.

April 10, 2008.

Respectfully submitted,

William W. Ware.
731 SW Salmon St. No. 807
Portland, Oregon 97205
503-227-5225
Pro Se Petitioner

IN THE SUPREME COURT OF THE
STATE OF OREGON

WILLIAM W. WARE
Petitioner, Petitioner on Review,
v.
DEPARTMENT OF HUMAN SERVICES
20050015, 20051662

Court of Appeals
A 128709 (Control)
A130218
SO55070

ORDER GRANTING MOTION FOR LEAVE TO FILE UNTIMELY MOTION FOR RECONSIDERATION AND DENYING MOTION FOR RECONSIDERATION

Upon consideration by the court.

The motion for leave to file untimely motion for reconsideration is granted. The motion for consideration is denied.

January 23, 2008 (signed)
Date Chief Justice

C:Richard D. Wasserman, William Ware

*

Appendix B 2a

FILED June 13, 2007

IN THE COURT OF APPEALS OF THE STATE OF OREGON

WILLIAM W. WARE
Petitioner, Petitioner on Review,
v.
DEPARTMENT OF HUMAN SERVICES
20050015, 20051662

A 128709 (Control)
A130218

Submitted on record and briefs: May 4, 2007

Before Laundau, Presideng Judge, and Schuman and Ortega, Judges

Attorney for Petitioner: William W. Ware, *pro se*
Attorney for Respondent, Richard D. Wasserman

AFFIRMED WITHOUT OPINION

Prevailing party; Respondent
(X) No costs allowed

Appellate Judgment Court of Appeals

Effective Date: February 14, 2008 (seal)

*

APPELLATE JUDGMENT
Page 1 of 1

IN THE SUPREME COURT OF THE
STATE OF OREGON

WILLIAM W. WARE
Petitioner, Petitioner on Review,
v.
DEPARTMENT OF HUMAN SERVICES
20050015, 20051662
Court of Appeals A 128709 (Control)
A130218
Oregon Supreme Court No. SO55070

ORDER DENYING REVIEW

Upon consideration by the court.

The Court has considered the petition for review and order that it be denied.

October 4, 2007 (signed)
Date Chief Justice

C: Richard D. Wasserman, William Ware

ORDER DENYING REVIEW

* REPLIES SHOULD BE SENT TO State Court Administrator, Records Sec. Supreme Court Bldg. 1163 State St., Salem, OR 9730142563

BEFORE THE OFFICE OF
ADMINISTRATIVE HEARINGS
STATE OF OREGON
for the
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF CLAIMANT	)	FINAL ORDER
	)	
	)	OAH Case No.
WILLIAM W. WARE	)	20051662
		Department Case No. FL4708

HISTORY OF THE CASE

On December 1, 2004, the Department of Human Services (Department) notified William Ware (Claimant) that his medical benefits would close December 31, 2004. On December 27, 2004, claimant requested a hearing to contest the closure. The Department referred claimant's request to the Office of Administrative Hearings (OAH) on January 5, 2005. Claimant requested and received aid paid pending.

On January 7, 2005, the Department mailed claimant a Notice of Food Stamp Over-issuance and Request for Repayment, informing claimant of an overpayment in food stamp benefits. On January 20, 2005, claimant

requested a hearing to contest the overpayment.

The OAH scheduled a hearing for February 15, 2005 regarding both the closure of claimant's medical benefits and the food stamp overpayment. The Department did not include the January 7, 2005 Notice of Food Stamp Overissuance and Request for Repayment in the hearing packet for the February 15, 2005 hearing.

OAH Administrative Law Judge Daina Upite presided over the February 15, 2005 telephone hearing. At that hearing, the Department withdrew the issue of whether claimant was overpaid food stamp benefits because the Department incorrectly believed that it had not yet issued a Notice of Food Stamp Over-issuance and Request for Repayment. On March 25, 2005 Administrative Law Judge Upite issued a final order, affirming the closure of claimant's medical benefits.

On April 11, 2005 the Department mailed claimant a Notice of Overpayment and Planned Action, informing claimant of an overpayment in medical benefits. On April 21, 2005 claimant requested a hearing to contest the medical benefit overpayment. The Department referred claimant's request

for hearing to the OAH on June 21, 2005, listing both the medical overpayment and the food stamp overpayment as hearing issues.

A telephone hearing was held on July 28, 2005, Administrative Law Judge Jennifer Rackstraw of the OAH presiding. Claimant represented himself at the hearing and testified on his own behalf. Judy Fowler represented the Department and testified on its behalf. The record closed at the end of the hearing on July 28, 2005.

ISSUES

1) Did claimant incur and overpayment in the Food Stamp program? If so, what is the amount of the overpayment and must it be repaid? See Oregon Administrative Rule (OAR 461-195-0501 et seq.; 7 C.F.R. Sec. 273.18. 1

Footonote 1 The Department's representative contended at hearing that the ALJ lacked jurisdiction to hear this issue because claimant did not request a hearing on the January 7, 2005 Notice of Food Stamp Over-issuance (sic)and Request for Repayment until April 21, 2005, and that a hearing was scheduled for

February 15, 2005, in part, to address that overpayment. (See Exs. A4 at 2, A3 at 10.) The fact that the Department withdrew the food stamp overpayment issue at the February 15, 2005 hearing based on the incorrect belief that the Department had not yet issued a Notice on the overpayment does not negate that a valid request for hearing on the food stamp overpayment exists. Thus, the ALJ has jurisdiction to address the issue.

2. Did claimant incur an overpayment in medical benefits paid while claimant received continuation of benefits pending the outcome of an administrative hearing? See OAR 461-025-0311; 461-195-0501; 461-195-0541.

EVIDENTIARY RULINGS

The Department's Exhibits A1 through a4 were admitted into the record without objection.

FINDINGS OF FACT

1. Claimant has been receiving food stamp and medical benefits through the Department at least since 2003. In January 2004, claimant reapplied for food stamp benefits for himself. He reported his income as $40.00 per

month. Based on that reported income, the Department re-certified claimant as eligible for food stamp benefits in the amount of $141.00 per month for the period February 2004 through February 2005. (Ex. A at 5-6.)

1. In February 2004, claimant became eligible for Social Security Disability (SSD) benefits in the amount of $963.00 per month (Exs. A3c at 8, A3 at 11; Test of Fowler.) On March 22, 2004 claimant received his first SSD payment in the amount of $2,796.00 (Ex. A3c at 4.) The Department did not learn of claimant's SSD income until October 12, 2004. (Ex.A3c at 10)

3. During the period February 2004 through September 2004 claimant received $141.00 per month in food stamp benefits. Claimant received $139.00 in food stamp benefits for the month of October 2004. (Ex.A3c at 3.)

4. Claimant was categorically eligible for food stamp benefits during all the months at issue because he had actual income each month of less that 185 percent of the amount listed in *former* OAR 461-155-0225(2)(a)(effective 4/01/04 through 2/17/05). Based on claimant's actual income, he was only entitled to receive $10. Per month in food stamp benefits from May 2004 through October

2004. Claimant was overpaid food stamp benefits in the following amounts: $131.00 per month for May 2004 through September 2004 and $139.00 for October 2004. (Ex.A3c at 10).

5. On January 7. 2005 the Department mailed claimant a Notice of Food Stamp Over-issuance) and Request for Repayment ordering claimant to repay $1,187.00 in overpaid food stamp benefits. (Ex A3b at 1). On January 20, 2005 claimant requested a hearing to contest the overpayment.(EX A4 at 2)

6. On December 1, 2004 the Department issued a Notification of Planned Action proposing to close claimant's medical benefits, effective December 31, 2004. (Ex. A3 at 19.) On December 27, 2004 claimant requested an administrative hearing to contest the closure.

7. Claimant elected to receive continuing medical benefits, pending the outcome of administrative hearing on the medical closure (Ex A3 at 1,15, 17; Test. Of Fowler.) During the period January 2005 through March 2005, the Department paid out $2,728.98 in medical benefits on claimant's behalf. (Ex. A3 at 1, 5-8.

CONCLUSIONS OF LAW

1. Claimant incurred food stamp overpayment of $794.00 for the period May 2004 through October 2004. Claimant is liable to repay that about to the Department.

2. Claimant incurred a medical benefit overpayment of $2,728.98 for the period January 2005 through March 2005. Claimant is liable to repay that amount to the Department.

OPINION

An overpayment is defined as a "cash medical or food stamp benefit received by or on behalf of a client, or a vendor payment made by the Department on behalf of a client, that exceeds the amount the client is eligible for(,)" OAR 461-195-0501 (1).

Overpayments are categorized as follows: Except as otherwise provided in subsection © of this section, an administrative error overpayment is an overpayment caused by any of the following circumstances; (A) The Department failed to reduce, suspend, or end benefits after timely receipt of information that required such action; (B) The Department failed to use the correct benefit standard;(C) The Department failed to compute or process

a payment correctly; (D) The Department failed to require a general assistance client to complete an interim assistance agreement; or (E) The Department committed a procedural error that was no fault of the filing group or authorized representative.

c) A *client error* overpayment is an overpayment caused by misunderstanding or error on the part of a client, a client's receipt of unreduced benefits pending a hearing decision, a client's failure to return a benefit known by the client to exceed the correct amount, or a client's use of a JOBS program support payment (see OAR 461-190-0211) used for other than the intended purpose. OAR 461 195-0501(2) (Emphasis in original); 7 CFR Sec. 273.18(b).

The Department contends that claimant incurred an overpayment in food stamp benefits for the period February 2004 through October 2004 and an over-payment in medical benefits for the period January 2005 through March 2005. The Department , after having previously determined claimant's household was entitled to receive benefits having issued those benefits, now has the burden of proving that the household was not entitled to receive

some or all of those benefits. See ORS.183.450(2) ("The burden of presenting evidence to support a fact or position in a contested case rests on the proponent off the fact or position.") Nichols v. Employment /div., 24 Or App 195, 198 (1976).

Food Stamp Overpayment
February, March and April 2004

Financial eligibility for food stamps is based on a household's income. See OAR 461-155-0190. The Department contends that claimant incurred a $393.00 overpayment in food stamp benefits for the period February through April 2004 ($131.00 overpayment for each of the three months) because claimant became eligible for SSD in February 2004 and the Department did not consider this SSD income when issuing food stamp benefits to claimant in February, March and April 2004.

However, the evidence indicates that claimant did not receive his first SSD payment until March 22, 2004. Because the Department is required to issue a continuing benefits notice and must give 10 days notice when benefits are reduced, claimant's change in income as of March 22, 2004 would not have affected his food stamp allotment until May 2004. See

OAR 461-180-0030. (footnote 2) OAR 461-180-0030(2) provides "when prospective budgeting is being used, the effective date for reducing benefits is the first day of the month following the month in which the decision notice period ends." Footnote 3, *Former* OAR 461-175-0030(3) (effective through 9/31/04) provides that, " timely continuing benefit notice *** (I)s mailed no later than ten calendar days before the effective date of the action.

May, June July, August, September, and October 2004

Because the Department failed to consider claimant's SSD income after his receipt of that income in March of 2004, claimant received more food stamp benefits that he was eligible to receive during the period May 2004 through October 2004. Based on claimant's earnings, he was eligible to receive only $60.00 in food stamp benefits during this period., whereas he received a total $854,00 in benefits. Footnote 4,Claimant was categorically eligible to receive $10.00 per month for each of the months at issue. See *former* (effective 10/01/02) and temporary (effective 8/01/04 through 9/31/04) OAR 461-165-0060(3)(a). As such, claimant did not incur a food stamp

overpayment for February through April 2004.Thus the Department overpaid claimant $794.00 in food stamp benefits during the period May 2004 through October 2004.

Forboth client-caused and agency – caused overpayments in the Food Stamp program, all adult members of the filing group at the time the excess benefits were issued are liable to repay the overpayment. OAR 461-195-0541(2)(a); 7 CFR 273.18(a)(4)(I). Therefore, claimant is liable to repay to the Department the $794.00 in excess food stamp benefits he received.

Medical Benefits Overpayment

Claimant elected to receive medical benefits for the period January 2005 through March 2005, pending the outcome of an administrative hearing regarding the proposed closure of his medical benefits. See OAR 461-025-0311. A final order issued March 25, 2005 ordered that claimant's medical benefits close December 31, 2004. As a result, claimant was not entitled to receive medical benefits for the period January 2005 through March 2005. The Department paid out $2,728.98 in medical benefits on claimant's behalf

during that time period-thus, creating a client-caused overpayment. See OAR 461-195-0501(1) and (2)©.

OAR 461-195-0541(3)(a) provides that the primary person, if that person is an adult, is liable to repay an overpayment in medical benefits. Therefore, claimant is liable to repay to the department $2,728.98 in excess medical benefits he received.

ORDER

1) The Department's Notice dated January 7, 2005 is MODIFIED. Claimant must repay to the Department $794.00 in overpaid food stamp benefits.

2) The Department's Notice dated April 11, 2005 is AFFIRMED. Claimant must repay to the Department $2,728.98 in overpaid medical benefits.

Signed: Jennifer H. Rackstraw, Administrative Law Judge, Office of Administrative Hearings.

Further appellate information omitted. Certificate of Mailing is dated 16th day of September 2005, in the foregoing Final Order in Ref. No. 20051662.

BEFORE THE OFFICE OF
ADMINISTRATIVE HEARINGS
STATE OF OREGON
for the
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF CLAIMANT	)	FINAL ORDER
	)	
	)	OAH Case No.
WILLIAM W. WARE	)	20050015
		Department Case No. FL4708

HISTORY OF THE CASE

On December 1, 2004, the Department of Human Services (Department) notified William Ware (Claimant) that his medical benefits would close December 31, 2004. On December 27, 2004, claimant requested a hearing to contest the closure. The Department referred claimant's request to the Office of Administrative Hearings (OAH) on January 5, 2005.

A telephone hearing was held on February 15, 2005. Administrative Law Judge Daina Upite of the Office of

Hearings presided. Claimant represented himself and appeared as a witness. Judy Fowler represented the Department and appeared as a witness The record closed at the end of the hearing on February 15, 2005

ISSUE

Whether claimant's medical benefits should close.Footnote 1 The Department's Notice of Contested Case and Pre-Hearing Summary identified the issue of whether claimant's food stamp benefits should be reduced to $10 per month, beginning January1, 2005, pursuant to a Notification of Planned Action mailed December 1, 2005. At hearing, claimant stated that he did not contest the reduction of his food stamp benefits, so this issue was not addressed in the hearing. The Department also identified the issue of whether claimant was overpaid food stamp benefits in the amount of $1,187 for the period February through October 2004. However, it appears that the Department has not issued a Notice of Over-Issuance of Food Stamp Benefits to claimant, so the overpayment issue was withdrawn by the Department at the hearing. (Ex A1; Test. Of claimant, Fowler).

EVIDENTIARY RULINGS

Exhibits A1 through A8, submitted by the Department were admitted into evidence. Claimant offered Exhibits 1 through 13, and the Department objected on the grounds that the documents are medical records and are not relevant in this hearing. Claimant contends that the documents are relevant to his argument that cutting off medical benefits while he is undergoing treatment for serious medical conditions is contrary to the legislative intent underlying the Oregon Health Plan. I acknowledge claimant's position. Nevertheless, Exhibits 1 through 13 are excluded as not relevant to the dispute before me.

FINDINGS OF FACT

1) Claimant had been receiving the Oregon Health Plan (OHP) Plus package of medical benefits since March 2004. Through December 31, 2004, the income limit for qualifying for OHP Plus benefits through the Oregon Supplemental Income Program was $565 per month. The income limit for qualifying for the OHP Standard medical package is $776 per month. (Test. Of Fowler)

2) In February 2004, claimant became eligible to receive benefits from the Social Security Administration (SSA) He received $963. Beginning January 1, 2005 claimant receives $990 per month in SSA benefits. Claimant receives Social Security Disability (SSD) benefits under Title II of the Social Security Act. Claimant is not currently eligible for Medicare benefits. (Test. Of claimant; Fowler; Ex.A5.)

3) Claimant was born August 27, 1952, and was 52 years old at the time of the hearing. He lives alone, and he does not need any assistance with his activities of daily living. (Ex.A3test. of claimant.) Claimant strenuously objects to the termination of his medical benefits when he just started treatment and is still very ill. (Test. Of claimant.)

CONCLUSION OF LAW

In order to be eligible for OHP medical benefits, a claimant's countable income cannot exceed the financial eligibility standard. To determine financial eligibility, the applicant's average countable income, which is assigned to the budget month, is measured against the appropriate income standard. Average countable income is

determined by adding the income for the A three months preceding the budget month and dividing by three. The result is the
income assigned to the budget month. OAR 461-150-0055(3). Social Security benefits are treated as unearned income. OAR 461-145-0490. Unearned income from SSB is not specifically excluded; therefore, such income is countable OAR 461-140-0010(2).
For the OSIP program (and the OHP Plus benefit package), the countable income limit for a single person was $565 per month through December 31, 2004. For the OHP Standard benefits package, the countable income limit for a single person is $776 per month. OAR 461-155-0225(2)(a). Claimants average countable income, consisting of his Social Security benefits, was $963 per month through December 31, 2004. Therefore, because claimant's income exceeded the income limits, he was not eligible for either OHP Plus or OHP

Standard benefit packages.

There is no evidence that claimant is responsible for a minor child in his household. Therefore claimant is not eligible for Temporary Assistance for Needy Family-related medical programs (i.e.,Medical Assistance Assumed and Medical Assistance to Families).

Claimant does not receive Medicare benefits. Consequently, he is not eligible. If claimant were receiving "waivered" services (in-home, community-based services). The income limit for qualifying for medical benefits would be higher. OAR 461-135-0750. However, claimant is not now receiving in-home services, nor does he need such services.

In finding that claimant is not eligible for OHP or any other Medicaid program, I cannot take into account that claimant has serious medical conditions that require medical treatment, Claimant would qualify for medical benefits, but for the fact that his SSB income exceeds the income limits for the Medicaid programs. I do not have the authority to waive the financial criteria for the programs.

ORDER

The Department's Notification of Planned Action mailed December 1, 2004 is AFFIRMED

Signed: Daina Upite, Administrative Law Judge, Office of Administrative Hearings

Further appellate information omitted.

Certificate of Mailing is dated 16th day of September 2005, in the foregoing Final Order in Ref. No. 20051662.

OREGON MAN'S DEATH PERSONIFIES NATIONAL MYOPIA By John Kitzhaber

As an emergency physician and former governor, On the same day that the U.S. House of Representatives voted to involve the federal courts in her case, it also approved a 10-year, $92 billion cut in Medicaid funding- $30 billion deeper than the cut recommended by President Bush.

The relationship between these two decisions – virtually unreported by most media – goes to the very heart of why we're unable to resolve the growing crisis in our health care system. While involving the federal courts in an attempt to save the life of one highly visible individual, Congress made a fiscal decision that will deny thousands of other Americans timely access to health care, some of whom may die as a result.

To understand this point is to understand the insidious form of implicit rationing practiced by legislative bodies though out the nation – starting with Congress. When the Congress cuts Medicaid funding, it is a direct cost shift to the states that administer the

23a- program. However, unlike Congress which has run up a $7 trillion national debt over the past four years, states are required to operate within a balanced budget. So they respond to cuts in Medicaid by dropping people and/or services from coverage.

In 2003, for example, in an effort to balance the budget in the face of falling revenue resulting from the recession, the Oregon Legislature discontinued prescription-drug coverage for certain categories of citizens covered by the state's Medicaid program. This action was apparently based on the assumption – widespread in legislative circles – that if we just stop paying for the health scarce needs of the poor, they'll somehow go away and the public sector can avoid the cost.

As a consequence of this decision, Douglas Schmidt, a man in his mid-30's suffering from a seizure disorder was no longer able to afford the medication that controlled his seizures. He subsequently had a grand mal seizure and suffered severe brain damage. He was put on a ventilator in a Portland hospital, where he remained for several months. Eventually he was transferred to a long-term care facility, where he died after life support was withdrawn following a court order

24a- The cost of his anti9-seizure medication was $14 a day; the cost of his hospital care was more than $7,500 a day – to a total medical bill exceeding $1 million. The Legislature saved no money through its implicit rationing decision, yet Schmidt died of political and budgetary expediency based on a policy that said, in effect, we will not pay pennies for medication to manage a seizure disorder, but will pay thousands of dollars to keep an individual on life support after that unmanaged seizure disorder causes severe brain damage.

It is a policy that says we will not pay to manage many very manageable health issues in ways that would prevent people from ending up in long-term hospital stays; or says we will not pay to provide all pregnant women with good prenatal care, but will pay to resuscitate their one-pound infants in a neonatal intensive care unit. This should not be acceptable to any of us.

Certainly no one in Congress could openly support this kind of policy; no one could justify the human consequences or the tremendous waste if taxpayer dollars. Yet that is exactly the policy Congress embraced when slashing Medicaid funding, even while calling for court intervention to save Terri Schiavo's life. Nobody in Congress rushed to give 25a- Douglas Schmidt access to the federal courts when he could no longer gain

25a· access to his medications. There was no moral outrage over his death – or the death of thousands of other Americans who die each year unable to afford timely access to health care. It is very much like high-level bombing where the pilots never see the faces of the people who suffer because of their actions. Schmidt was a statistic – one of the many millions of Americans who had no way to pay medical care. The cause of his death was not as dramatic, and therefore not as newsworthy, as the plight of Terri Schiavo. But it was no less tragic because it went largely unreported.

This nation, its political leadership and its media need to be willing to express the same concern and invest the same energy in ensuring that all Americans have timely access to needed care that they do in responding to the plight of highly visible individuals. Until then, the crisis our health care system will continue to deepen. If indeed we claim to be a society guided by moral values, then surely we cannot apply them selectively.

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